



EVALUATION REPORT¹ SEXUAL VIOLENCE PROJECT

MEDICOS SIN FRONTERAS (MSF-CH) GUATEMALA



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A 30 year old woman who was married with 4 children went to a store to make a payment. On the way, she was mugged by 2 men. Seeing some police nearby, she went and asked for help. They asked her to get into the car to assist in looking for the thieves. Instead of following the 2 men, they took her to an abandoned lot, a lot where two months prior her brother had been murdered. She was taken from the car, stripped and raped. As one of the perpetrators started to sexually violate her with his gun, his colleagues stopped him, now he had gone too far. They jumped in the car and drove away. She was left behind in the lot where her brother was killed: mugged, stripped, and raped.

Someone came to her aid and took her to a hospital. There was no HIV test available, no post exposure prophylaxis, no morning after pill, and no hepatitis B vaccine. Follow up care was nominal. 15 days later she found out that she was pregnant, and in despair tried to kill herself, but she was rescued and taken to MSF. Whatever medical treatments that could be given to her were given by our team, and psychological therapy commenced. As she progressed in the therapy, she not only started to deal with this trauma but also understood and confronted the fact that she had been sexually abused as a child. As well, she found the strength to tell her husband what happened. They agreed to keep the baby.

Guatemala is among the most violent countries in the world. Although general violence is well understood in Guatemala, sexual violence is cloaked in silence. It is not dealt with, it is not acknowledged, and in fact for many it is not even understood. Through giving attention to sexual violence, and providing desperately needed care, along with a network of others, MSF has managed to start breaking the barrier of silence. Despite the risks of retaliation in a society where impunity reigns, women are starting to step forward in larger numbers, and bit by bit others are there to respond with humanity that eventually allows for women to recuperate and rediscover their dignity.

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1. INTRODUCTION

This evaluation was requested by MSF CH Geneva and focuses on the pertinence, efficacy and impact of the sexual violence project in Guatemala, (see annex 1). The motivation to evaluate this program stemmed from difficulties at the initial stages of the project in realizing the goals through the original strategies chosen.

The results answer key questions about the added value of the intervention regarding the problem of the sexual violence (SV). This includes establishing the advantages and disadvantages of the intervention by an international humanitarian organization such as MSF, mostly through the perceptions of the different collaborating internal and external actors on the ground: the status of the project, the appropriateness of the strategy with regard to the victims' needs, and intervention choices; the suitability of collaboration with the Ministry of Health and the Attorney General's Office (MP); and the capacity of MSF to face the challenges in the development of the Project.

From January 12th through 22nd 2009, the evaluators interviewed fifteen members of the MSF-CH team in Guatemala, and twelve external actors who collaborate with the Project, (see annex 2). Preliminary conclusions were presented to the field team on the last day of the evaluation and to the MSF Swiss program responsible for the desk subsequent to the evaluation. The program responsible and the medical referent for violence were also interviewed at the HQ level.

The humanitarian commitment and professionalism of the entire team who collaborated in the exhaustive understanding of actions, and offered practical recommendations to improve the Project were remarkable. With that, the evaluators would like to extend a thanks to all those involved.

2. SUMMARY OF CONCLUSIONS and key *RECOMMENDATIONS*²

MSF-CH is just beginning to obtain a relevant impact: not only in medical and psychological assistance to the people who came to the service, but also on more broad levels regarding sexual violence. Beyond the medical and psychological inputs, it is clear that the MSF-CH project has the capacity to benefit the Guatemalan people in general through catalyzing significant changes within the country pertaining to the issue of sexual violence and needed responses.

In regard to medical assistance, even though MSF-CH already had a good image among the people who came to the service, it is clear that the process is only beginning, taking into consideration the potential number of cases of sexual violence who would need attention. Although accurate general statistics are yet unknown, it is sufficiently apparent that a considerable number of cases still have not had access to medical and psychological assistance. This is related to several factors including the general understanding of violence, the lack of will to provide attention among the Ministry of Health medical staff, and a true fear about the consequences related to the imposed legal process due to the high level of impunity in the country.

In spite of many difficulties, together with other key organizations MSF-CH is starting to break the traditional silence around the theme of sexual violence in the country.

Strategically, MSF-CH recently adjusted their approach and chose a very logical work system to have access to the patients. At the very beginning, the choice of working at the peripheral clinics within the more violent areas was accompanied by an understandable delay in the activities due to the fear of possible revenge acts, the medical staff's resistance, and the limited knowledge on the subject by

² Please note that throughout the report recommendations are in italics

the general public, along with the original internal choice by MSF to remotely base MSF staff away from the clinics. In order to address the protracted start, the MSF team has based themselves directly in the peripheral clinics and re-oriented community activities. Links on a more medical basis have been developed which allow for a more intensive interaction and heightened medical and psychological impact.

Rather controversially, the team has also added a clinic in the Attorney General's Office (Ministerio Publico, MP). Despite the potential risks of working at the Attorney General's Office, it is important to highlight that risks to independence, and risks to perceptions of independence are minimal at this point. All surveyed individuals clearly expressed that independence is more related to the status of the international organization as an international organization instead of the location of the clinic. This was also confirmed through the recent MSF CH perceptions study. In any case, MSF-CH's presence is more likely to improve the reputation of the Attorney General's Office, as opposed to the Attorney General's Office jeopardizing the reputation of MSF-CH.

It is also important to point out that working in the MP has been actually the door that had to be opened in order to establish the planned route for project development which should include the extremely important expansion to San Juan de Dios Hospital to better serve those subjected to sexual violence within MSF's catchment areas within Northern Guatemala City.

Once it becomes possible to work at the San Juan de Dios Hospital, MSF-CH's staff at the Attorney General's Office clinic should then move to the Hospital. This must be clear for the parties involved and the right time to leave the Attorney General's office should be estimated according to the existing needs at both, the Attorney General's Office and San Juan de Dios Hospital. It is important to keep good relations with the Attorney General's Office to enable the transfer of future cases from the Attorney General's Office to the hospital supported by MSF.

Nevertheless, in the interim it is important to carefully monitor the extent of independent functioning and the perceptions with the external actors. It is clear that MSF-CH should not provide unrestricted support to the Attorney General's Office, not even supervise and verify the activities to be developed by the Attorney General's Office. MSF-CH should instead limit the work to the clinic and make sure that communication routes between the MSF-CH teams and the Attorney General's Office are adequate.

The future development of the project should be focused on the strengthening the chosen framework. It is not advisable to subsequently extend the project beyond what would be necessary to improve the access for patients in zones 7 and 18, the MP in the interim, and eventually San Juan de Dios Hospital. By limiting the intervention to these places, the team will have a better management of all the facts related to such a complicated and sensitive topic.

Throughout the evaluation it was clear that the greatest potential value of MSF's role comes from a focused medical and psychological response. With sexual violence being so pervasive in an environment of impunity, MSF not only has chosen a neglected need, but has done so in a way that helps to minimize risks to patients and staff.

It is extremely important to keep working only in the medical field. MSF-CH could reach outstanding impact simply by choosing to provide medical and psychological assistance. Keeping this procedure will also minimize the security risks related to sexual violence intervention within the Guatemalan context while other organizations manage the other components of response.

It is very important to promote information, education and communication activities in order to increase awareness. However, the need of focusing activities

to key groups instead of anyone who wants to listen is particularly evident. It would be valuable to identify key groups according to the resulting impact.

Communicating about sexual violence is extremely important. However, the team is only treating a small proportion of those affected, and the capacity to increase is limited at this point. Knowing there is the beginnings of a fundamental shift in Guatemala around addressing sexual violence, and that women are starting to step forward more, the timing of public campaigns is crucial to make sure that those stepping forward will have services available.

Hence, it is possible and advisable to launch a communication campaign on medical consequences of sexual violation, but only after the activities at San Juan de Dios Hospital have begun. It is essential to wait until the activities have been launched in the hospital due to an expected significant increase in the numbers of cases linked to the communications.

When communicating, the emphasis should be operationally based in the medical and psychological areas. Communications focused on the activities will help to augment MSF's access to those affected through building awareness, while minimizing risks associated with communicating on more sensitive matters and catalyzing greater change and impact.

MSF has developed solid links within the network of organizations dealing with sexual violence. The network of contacts is a crucial factor of the program. It assures an element of protection for the organization and staff consistent with the number of organizations involved with a very specific role.

To this effect it is important that MSF-CH does not get involved in the legal aspect regarding minors or provide shelter to cases, but instead continues to refer the cases to other organizations which actually take charge of these components.

The contacts within the network are well developed although there were some uncovered areas with regards to medical networking.

In order to strengthen the technical medical knowledge and the support, MSF-CH should consider playing a stronger medical role within the political network. Having the MSF-CH medical team already linked to the Ministry of health staff through the project, it is quite possible to create a strong and well empowered team that could continue and complete the work started by MSF-CH at the higher MoH levels.

Both the medical and psychology interventions are comprehensive in their respective protocols and procedures. The volume of work between the two disciplines is clearly different on the basis of patients' physical and psychological needs. The psychologists have a greater volume of work and the team is already making adjustments by increasing human resources; *nevertheless it is easy to anticipate that more arrangements will be needed in the future with the psychologists to keep an adequate workload and allow for continued quality support. In addition, it is anticipated that more MSF staff will be required for the San Juan de Dios hospital beyond what has been expected. It is recommended that planning integrates these staffing needs.*

In terms of professional supervision for the medical and psychological staff, we suggest supervising the medical team on two levels: at the beginning according to the specialty in order to build up capacities, and later in an interdisciplinary manner in order to benefit from synergistic interactions and assure comprehensive care.

The MSF team is pushing themselves while showing great interest for this new and exciting project. The commitment is similar to that normally seen in emergency intervention: Long hours of work, working on weekends, dealing with very intensive topics and with that, holding intensive discussions. Even

though it is clear that motivation and commitment are very strong, the evaluators are concerned for the team getting too tired and potentially burnt out.

To protect the team we suggest that the meetings take place during regular working hours, although this will imply leaving the clinic earlier once a week. Working overtime should be an individual choice, and not structured so as to give space to those needing time off to recuperate.

Even though the security risks are well handled and minimized by the team, it is clear that problems with threats will occur at some point due to the nature of sexual violence within the context of Guatemala. With that, MSF-CH should keep a high level of attention to security management and always be ready to handle the possible threats.

Overall, the team has managed to develop an outstanding operational balance; the difficult part will be to keep the same direction whenever turnover of key staff such as the head of mission and the medical coordinator occurs. Then, it is advisable for successors to have the possibility of having a complete and exhaustive handover to clearly understand the context and the project.

Although the project started in 2007, it only began to show significant steps forward about six months prior to the evaluation. It is necessary to take this into consideration when establishing the duration of the intervention. We suggest that the project be planned for the next three years for consolidation and followed by a handover phase of two years. With this timeframe, it is anticipated that MSF-CH will have an sufficient impact over the lives of many patients and the general situation of sexual violence in Guatemala³.

³ The external evaluator suggested 10 years was more appropriate timeframe, however taking into consideration the dynamic and planning cycles of MSF the timeframe suggested was compromised to that recommended in the report.

Basically MSF-CH has developed a very sensible project and is starting to reach the key time for its definitive development, focusing on the medical/psychological parts the impact will be very solid and the risks minimized.

3. GUATEMALAN CONTEXT

Very heart rendering types of social violence from different sources have increased in an unstoppable way during the last twelve years, after the signing of the Peace Accords in December, 1996.

The Ombudsman admitted that the year 2008 has been the most violent year of Guatemalan history (Prensa Libre; 12-28-2008). The comparative indicators, since 1999 to 2008, show that in nine years the number of homicides has doubled to 5885 in 2008 (PL 12-12-08).

Accordingly, among Guatemalans violence has produced a generalized atmosphere of fear and insecurity and a feeling of impotence to revert the situation affecting more than a third of the total population. With the majority of cases not reported due to a lack of trust in the political legal system to change the situation, the dynamic of impunity is reinforced and increasing the social request for an “iron hand” to deal with citizens’ insecurity.

As shown by the PNUD information (Prensa Libre 12-12-07) most of the victims are young, and both sexes are affected at almost the same level. One third of the families have been victims of some kind of violence, but as mentioned more than two thirds of crimes are not reported due to the experience of impunity and impotence suffered by the people increases their distrust on the institutions.

37.3%	74.9%	59%	9.8%	54.4%	35%	69%	61.5%	75.8%
Victimized homes Jun-Dec 2007	Offenses are not reported	Do believe reporting is useless	Afraid of reprisals	Victims are men	Victims between are 18-26 years old	Offenders are men	Insecurity is the main problem	Believe iron hand is the solution for insecurity

Insecurity has saturated peoples' tolerance expectations for change. Last year the press often expressed the general discouragement and the sensation that the "Guatemalan society is depressed" This has been supported by the information provided by the psychiatric consultation at the Peripheral Clinic in Zone 18 showing indicators of up to 40% of depression and anxiety disorders among women going to consult.

This comment serves to visualize the high level of violence and impunity that continues tearing the social tissue. A deep result of the impact of this structural and chronic violence in Guatemala is devaluation of life which, united to extreme poverty conditions, makes people feel more helpless and weakens their capacity of response, including those needing to seek help when sexually assaulted.

The press has made echoes about how these facts have caused uncertainty around the psycho-social reconstruction of the Guatemalan society. The experts ask themselves: are we so very unemotional? In allusion to the passiveness of the Guatemalan people against violence (El Periódico 11-8-2008, 4-5) it is questioned: Would fatalism be another consequence of how violence tears the social fabric? Others say that as a country we "should get out of silence to go into action" and and move away from "keeping the frustration in private, within the family" (Raúl de la Horra), and "cultivating indifference in front of so many deaths." (Otilia Lux de Coti), which is precisely as a result of the habit of government inaction and weakness, as well as lack of political will to take this social responsibility.

Among the justifying speeches from the "Unsuccessful State" and explanations on the "People's Impotence" as a long-term consequence, appears the repressive violence from the past connected to the present types of social violence repeating the atrocity patterns, protecting the responsible, and nurturing a whole chain of intermediaries who operate the network of organized crime and delinquency. These intermediaries impose the terror along the peripheral areas and do not forgive disloyalty from those considered their subordinates. Women are changing

the roles and besides being traditional victims of a humiliating violence that subjugates them, are now being recruited by the crime and are leading violent gangs, assassinating in cold blood. With this situation, fear is a defense facing the permanent uncertainty and, of course, explains the resistance found in dealing with sexual violence in Guatemala. “Just working in Guatemala is risky”; “even criminals need the projects on health assistance”. The lack of leaders and distrust on the institutions are justified in the present context of the organized crime by the “frightening disparity between the power of delinquency and the power of the State.”

The violence against women is devastating, for instance “155 women were killed by domestic violence in August 2008” (El Periódico 11-8-08). “During 2008, more than 600 women were murdered in Guatemala.” Comparing monthly numbers with those of the previous year (idem, 3-8-09) the number of women assassinated increased in February (2009; 66), mostly housewives. These crimes usually occur after repeated accusations of domestic violence.

One of the specific proposals to fight the violence against women was the approval of the ACT AGAINST FEMICIDE by the Congress of the Republic in May, 2008 (El Periódico, November 22, 2008). As a result of enacting this law funds were given to the operation of four centers of integral assistance to women (Atención Integral a Mujeres, CAIMUS) throughout the country and, currently, to the Unit for Victim Assistance (Unidad de Atención a la Víctima), a division of the Attorney General’s office, which provides medical and psychological support along side the accusation process during the day, and creates a more favorable situation for the victims involved in reporting and legal processes. Information provided by the Judicial Body to prevent and eradicate the violence shows that if the government responds, people do start to trust the institutions.

Cases taken care by the government 2008 (El Periódico 11-22-08)

Judicial Body has received 674 cases of violence against women
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Women Attention Division at the Attorney General's office has filed 220 cases for physical and sexual violence against women

The Women Attention Division has received 156 accusations for economic violence

Attorney General's Office registered 1520 accusations

4. THE PROJECT BACKGROUND

The serious magnitude of sexual violence and the lack of attention by the health sector were noticed during the implementation of the HIV-AIDS program by MSF CH in Roosevelt Hospital. Through an understanding of Guatemala and direct experience within the HIV/AIDs project, teams noted the need to address sexual violence since the fear, silence and denial were stigmatizing victims of sexual violence to a point of preventing people from asking for help. This led to further investigation which included a preliminary research on the problems of sexual violence in zone 18 done in 2005.

It was not until April 2007 that the MSF-CH sexual violence project in Guatemala City officially started. It was at this time that the previous project on HIV-AIDS was in handover phase and closing (October 2007).

In terms of other medical inputs, at the beginning of the project, the MOH only had clinical assistance for sexual violence within Guatemala City in the clinics of the HIV-AIDS program located at the Roosevelt Hospital where there were trained and experienced health staff available, but where there was limited access to the emergency medication kits for sexual violence.

The MSF sexual violence project first began in the Peripheral Clinic of Zone 18 as it was established as one of the "red areas" with priority in the map of metropolitan violence. This zone received a migratory flow of people from the north and east sides of Guatemala. These areas were known to also have high levels of violence, and those entering zone 18 brought this pattern with them, along with high numbers of sexual violence cases.

The beginning of the project was very difficult due to a number of internal and external factors. As consistent with the general situation in Guatemala, externally the MSF team faced a strong social resistance to break the silence, and the

institutional resistance to approach the clinical consequences of the sexual violence; in addition, there was a lack of an adequate focus to motivate the victims to ask for help. Choosing the most violent area as a starting point also meant a greater degree of challenge in pushing through these barriers. The greatest resistance noted arose from the possible legal repercussions derived from the fear of working in zones of high risk of violence and reprisals from the relatives in case of accusation. Internally the original project design did not lend itself to effective outcomes.

In response to the limited impact of the project, by mid 2008 it was decided to change from strategies which were essentially coordinating with the Ministry of Health in Guatemala (MSPAS/MoH) to opening direct clinical assistance services within the public health services. The access and availability in zone 18 peripheral clinic in combination with a second peripheral clinic in the highly violent marginal urban zone 7 were negotiated in order to attract the demand and extend the clinical assistance to sexual violence cases.

MSF-CH was in a good position to negotiate this and collaborate with the Ministry of Health because of their previous working relations within the HIV/AIDs project among other interventions in the country.

The MOH was involved with technical advisors to prepare the re-newed cooperation agreement with MSF-CH. In view of such interest, a follow-up was a must. After signing the agreement, the MSF team noted that they were able to work faster and more effectively than in previous projects such as Roosevelt Hospital.

The work commenced where the team had been previously providing a remote support in Zone 18, and later, the project opened services at the Peripheral Clinic of zone 7, then opened a clinic at the Attorney General's office, and now the team is negotiating with the MoH to open services for sexual violence patients at San

Juan de Dios Hospital. This last expansion is an extremely important step in building the impact to appreciable levels, as this particular hospital gathers the demand of assistance from the central part of the city and the northern area which lacks clinical assistance infrastructure regarding sexual violence.

The many changes in the approaching strategy which allowed the project to effectively start in mid 2008, included:

- a) Building up the project coverage in four urban services, two in the center of the Capital City and two in the metropolitan area.
- b) Shifting from a mobile support capacity to a combination of ambulatory support in balance with full time stable presence of multidisciplinary MSF health teams.
- c) Physically working in the national structures of the health system, creating new and independent services of high demand within the MoH/MP facilities with a view to the services being incorporated into the Ministry of Health at middle term. "As an NGO they are not allowed to interfere in the politics, but they can pressure the Ministry of Health to respond to these problems."
- d) Directly hiring the technical teams to avoid the problems faced when MOH was only remotely supported (2007-2008). Consequently, this improved the working environment and the commitment of the team with a good professional practice.
- e) Negotiating with the authorities that MSF focus on the medical and psychological response, leaving the legal aspects to the individual's choice, reducing fear associated with care.
- f) Streamlining and medicalizing the topics of discussion in community activities
- g) Building the networking role of MSF and connections with other organizations.

In summary, MSF-CH focuses on initiating a service in sexual violence response that did not exist before in Guatemala City to any appreciable level from a medical and psychological perspective.

5. THE PROJECT and IMPACT OF ACTION since mid 2008.

MSF-CH's underlying policy for this project is to open services of clinical assistance inside the facilities of the Ministry of Health in order to treat patients while pressuring and forcing the institutionalization of these services in the mid term. The overall success of this policy will depend on access to patients along with the will of the public officers, both which will require time to realize. In fact, there has been much more receptiveness from Roosevelt Hospital authorities than those from San Juan de Dios for agreements and strategic alliances. The previous project on HIV-AIDS with Roosevelt Hospital has kept the doors open along with an excellent relation of collaboration between MSF-CH and the professionals of this health service.

"This strategy of opening services inside the system is an important precedent, so it will not be easily closed following handover." Although MSF-CH has had success with this in the past, it is important to keep in mind that several health programs have been opened with the support of other international cooperation efforts and then closed afterwards due to the incapacity of the Guatemalan government to integrate the service, even if there was a high demand from people for the services. It is elements such as this, which highlights the need for a protracted timeframe in the implementation phase which should include comprehensive negotiations, agreements, and inputs around handover, along with an extended handover phase to reach success.

ACCESS TO REHABILITATION SERVICES FOR VICTIMS.

The access to services provided by MSF-CH includes medical and psychological assistance, the equipment of services, the necessary referrals, and the record of cases. The project also carries out awareness activities and promotional campaigns in clinics and community locations for the victims to seek specialized

help, and train external/MoH staff involved in the Project together with other Actors.

The activities of the MSF-CH Project in Guatemala as developed :

1. Opening services of medical and psychological assistance in four clinics, in coordination with the Ministry of Health, the Attorney General's office and Non Governmental Organizations of the Civil Society. The four services have been gradually opened and the teams are in the process of integrating into:
 - a) MoH Peripheral Clinic, Zone 18 for 300,000 people: This clinic offers emergency care, OPD, psychiatry, psychosocial services and dental care. Overall the peripheral clinic in zone 18 is staffed with MoH staff from the area and they see approximately 60 to 70 patients per day.
 - b) MoH Peripheral Clinic Zone 7 for 100,000 people: This clinic offers emergency care, OPD, maternity, psychosocial care and dental services. The MoH staff come from different parts of the city, and see approximately 120 to 130 patients per day.
 - c) Attorney General's office: Office of assistance to victims of violence.
 - d) Mobile Unit/ Zone 1: MSF is temporarily sharing the space with *Clinicas de Fundación de Sobrevivientes y Grupo Guatemalteco de Mujeres*. for referred cases. As well, it is planned to open a clinic in February 2009, *Centro de Salud, Zona 1*, as a transitional solution until negotiating the opening of service at San Juan de Dios Hospital.

2. Participation in National networks of Governmental Organizations and Non Governmental of the Civil Society for the exchange and updating the information on the context related to sexual violence. The network collaboration and the alliances with organizations that are heard by the government have affected the negotiations of MSF-CH with the government to

open the services and start giving answers. The immersion in the Civil Society (CS) networks involved in the prevention and eradication of sexual violence supports the MSF-CH intervention in this field, contributing to the necessary addition of efforts.

3. Training MSF-CH technical staff and related health services in the use of Sexual Violence Protocol of the MOH (version 2007, being reviewed).
4. Information, education and communication to have an influence on behavioral changes that facilitate the access to services and seek for medical and psychological help in cases of sexual violence. There has been some collaboration in the urban areas from the Fire Departments (*Municipales* and *Voluntarios*) and with the National Civil Police to sensitize and improve the response of public officers towards the victims requiring immediate help. The results have not been quite productive because actions have been scarce and disperse.

IMPACT OF ACTIONS ON THE VICTIMS AND THE HEALTH SYSTEM

Even though MSF-CH defines sexual violence as a “medical and psychological emergency”, all consulted Actors consider that it is not a disease but an existing social issue caused by the political and cultural history and the context of impunity in Guatemala. “Therefore, little changes of political opening, information on sexual violence and legal support to the victims have caused an increase of new cases looking for help” (PNSM).

From this definition arises the need for MSF-CH to participate in the Civil Society and government networks, to keep an accurate analysis of the intervention within the context in order to guard appropriate and safe project development. This participation will also add to the coordinated efforts that together guarantee

comprehensive assistance in response to the victims' needs. The MSF-CH project in this case directly takes care of medical and psychological damages and refers the cases to other NGOs specialized in filing legal cases, shelters etc. This guarantees the access to all components: psychological, medical, social and legal assistance by giving a model of integral attention from a holistic perspective. "An added value of integral assistance is to empower and demand rights and legal punishment." (PNSM)

Whether part of MSF's own policies or not, the team is facing the living history of the country as a result of sinister practices from the past and its effects on the society. Within the health system there are those who collaborated with repression, and currently oppose the renewal of the Sexual Violence Protocol and provide assistance at public health centers. Therefore, it is recommended to "involve teams in understanding the context and violence cycles, standardize the type of approach regarding the assistance model, guarantee supervision by the review of practical cases, and the emotional impact caused on psychologists." (PNSM). This allows a greater understanding of the broader impact to which MSF contributes.

The objective risks of working within the sexual violence field are:

1. Social frustration due to unsuccessful sentencing legal actions. Aggressors are not punished. "There is fear of reprisals from aggressors because there is neither guarantee of not repeating the sexual offenses nor protection to witnesses due to prevailing impunity." This is why most cases assisted do not want to report.
2. Not being able to answer the scale of demand, compromising the quality of assistance.
3. Risk of reprisals to health staff for working in cases of legal impact in red areas, where the aggressors are gang members, drug dealers and feared criminals.

Impacts produced by actions of intervention of the project include:

1. Reduce the number of victims of sexual violence affected by sexually transmitted diseases through the access to tests and emergency kits.
2. Availability of a proper and effective service in helping the victim to recover.
3. Set a quality standard in a pattern replicated by the MOH (if repeatedly implemented for several years, it becomes a standard of attention).
4. Opening the service within the health system does pressure and force the government to respond. Lobbying must be continued with the MOH to be included in the political agenda on health and to have the Government commit with a public policy to eradicate sexual violence.

Strategy of access to services

Two strategies have been essential to facilitate the access to services

- a) Attraction of demand.
- b) Confidentiality.

At the peripheral clinics sensitizing activities are carried out every day to detect possible cases. With separated but complementary tasks both contribute to sort the cases and refer them to medical and psychological consultation, guaranteeing confidentiality.

The technical team is aware of the necessary confidentiality as a strategy to help and protect the victims. The team carefully makes sure not to publicly identify patients, so they remain unnoticed to avoid the related risks. Such exposure could well have implications for the security and presence of MSF as well, which in turn could generate distrust by frustrating expectations among the community. As we know, the approach of sexual violence requires to be handled with ability and absolute discretion to avoid risks with victims and teams. Vulnerability increases

for victims are attacked within their immediate surroundings, since relatives or local delinquents are those who frighten and silence them with threats.

The location of the clinics is strategic to provide the service at local level, but the increase of security risks for the victims must also be considered. In summary, to break the silence on the issue and look for professional help it is essential to guarantee confidentiality responding to the created expectations, which is handled by the MSF-CH team with a good sense.

The tactic of being informally open to assisting different types of violence cases has been effective to get the trust of those who need to ask for help and avoid the stigma of being recognized. "With good treatment you pass the word and when you respond people come back." "I suggest concrete actions and help them make decisions."

According to the experience of social workers, patients look to MSF-CH for previous cases of violence, usually because people feel bad and have symptoms or suffer chronic disorders. With regard to new emergencies "we do not let patients go if they are recent SV. Patients always receive assistance and come back at the next appointment because there is a great need of help."

Although there is an informal openness to see any violence case that presents to reduce stigma, it is questioned if MSF should formally branch into general violence cases, as the Guatemala system is well set up for general violence medical response (gun shot wounds etc).

Along with attraction of demand and confidentiality other important components which have been identified include quality, ethics, professionalism, free service, and very functional closeness/decentralization.

“When people arrive at the clinic perceive an atmosphere of support and response. The patient is accompanied to the different services, receives personalized assistance and relieving explanations.” The authorities from the Health Center value the project as strength and present the results at the *situational room* of health. In general there is the beginning of a good integration between the MSF-CH and the Health System teams.

Medical and psychological agenda

The types of violence presented by assisted cases are multiple, from sexual abuse and mistreatment, sexual violations (collective, repeated), torture, incest, to other sexual offenses. There is concern about the increase of “date rape” cases (five cases in December in zone one) in young ladies (13 to 21 years) after being kidnapped, drugged and raped collectively. It is speculated that the purpose of using drugs is to hide evidence and avoid accusation.

The more frequent stories given by the victims are of accumulative trauma adding the experiences of violations to human rights during the war, domestic violence and current sexual offenses, including the significant problem of incest, which is actually more frequent than expected.

Staff express being concerned about having an excessive demand of services as a result of sexual violence. “We are not still able to make a considerable number of referrals since MSF-CH does not have enough capacity to respond; the project has a limited capacity and this must be adjusted to the new expectations”. This is why there is consensus about the need of “opening new spaces with other NGOs in order to extend assistance services to the victims.”

The limitations of services are also hindered due to the lack of trained and competent professionals working with sexual violence issues. Related to this, there is a strong fear to repercussions or being called to trial as experts in the cases

in which victims file accusation. "If I do not touch the abused body, I do not testify, I do not have the evidence and, therefore, I will not be legally involved." Doctors defend themselves justifying that sexual violence is not officially a recognized morbidity, but sometimes the origin of their resistance arises from hiding reality"; some workers of the health system are also aggressors at their own homes" and feel identified and threatened at the time of facing the issues of their work.

The work of awareness and education must be gradually extended to contribute in changing the mentality of resistance, starting from the health service itself and the Health Ministry officers. The recent accusation filed by an elder lady raped by a doctor, involved the complicity of the Attorney General's office itself, whose officers made fun of her while she was undertaking the corresponding procedures. "So what? The lady is not bad at all!" This type of offensive and cruel comments deserves efforts to achieve awareness and respect and change the mentality of public officers. This is the type of offense that the victims must face in their way of looking for repairing help and file an accusation. We suggest that this work can be extended to educational courses together with the staff of the centers where the services are rendered.

Intervention Tools

Basically, three technical tools are used: a) the SV Protocol; b) Self-aid groups and c) Follow-up of cases. MSF-CH has coordinated works with the *Programa Nacional de Salud Mental (PNSM)* (National Mental Health Program) sharing information and participating in the revision of the *Protocolo de Violencia Sexual del MOH (2007)*⁴, which content responds to a medical approach but lacks a psychological focus with a more holistic perspective of the approach. Currently, the Sexual Violence Protocol has been sent for final review to the Reproductive Health Program of the MOH. The advantage is that it is the 7th item in the public

⁴ This is the Protocol used at this time by health professionals, but it needs a thorough review for being inadequate and insufficient regarding the psychological approach more than in the treatments.

health agenda. The disadvantage is that the psychological approach needed may be rejected, as it was incorporated to the last PNSM review. Even though this Protocol is outdated and not comprehensive, it is the tool currently being used. Meanwhile, the National Program of Mental Health (PNSM) has a protocol on domestic violence (2008), which is very useful as a tool of psychological intervention.

It is important to push for the approval of the new Sexual Violence Protocol because of the professional need to have available tools which promote more current practices with an appropriate perspective. There are new challenges in the approach of these issues and it is advisable to strengthen the specialized training of the technical team along with advocating for the protocol.

Steps to detect cases.

In the clinics, the first contact is done by the educator-nurse who handles the agenda of assistance to cases and sorts the victims by observing their reactions to an awareness video showed at the outpatient-care waiting room in each clinic, "identifying with specific indicators the women who could be in crisis." The patient is contacted, personally and discreetly, and is offered the service guaranteeing the necessary confidentiality. Once this contact is made and after the initial exploration of what is happening to her comes the appropriate reference to the medical and/or psychological treatment.

Efforts are also undertaken in the communities. This is a very interesting opportunity on a number of levels. The consensus that sexual violence is not a disease but a social problem with very serious dimensions could be taken more into consideration within MSF through the community awareness and education activities. By joining the attention and prevention messaging a more adapted and integral intervention could be achieved and contribute to eradicate sexual violence.

It is recommended to consider incorporating preventive work with the community through information and education for change. This need has been identified because sexual violence takes place within families, marriages, group of friends, and is associated to machismo and the culture of violence. Although preventive work does not visualize the results at a short term, it is more effective to bring indicators down and reduce social impact. Awareness campaigns for looking for help and educate to prevent violence are compatible. The educational messages can be integrated to promotional campaigns performed by MSF-CH in association with other public and private actors. The extent to which MSF CH is willing to engage in prevention, however, will depend on the overall operational policy.

Another consideration around the community work is that this activity has significant impact on the security and protection of the victims and the technical teams through the alliance with the community leaders at work fields. Contacting and explaining to them the purpose of the project is important to count on their support and protection in the neighborhood. There is guarantee while being accompanied by the leaders during awareness and education activities, to promote and spread the project and invite victims to look for professional help.

Some limitations evaluated by the educators indicate that many people is being attracted but not actually assisted, which generates frustration of expectations and risks distrust in the operation of the system.

At the beginning of the project, the space was shared and the direct assistance was complemented by MOH professionals. It was thought that this way of cooperation would facilitate the training of technicians and leave installed capacity at the Ministry. However, it was necessary to change this agreement for the lack of technicians, especially psychologists available from the Ministry of Health and their little receptiveness demonstrated for working as a team. The change was a relief for all, giving priority to establish trusting relations to reach

mutual support between the Ministry of Health and MSF-CH teams without going into competition but accepting to cover the vacant of shifts and technical capacities of the system.

In addition, there is a huge resistance among doctors of the health system to assist cases of sexual violence, due to ignorance of the issue, objective risks, and sometimes for protecting or being afraid of known aggressors. The team values that these attitudes of resistance are starting to be overcome as a result of the collaboration and communication with the staff of health services instead of an imposed policy.

The Mobile Unit

The mobile unit receives more cases of recent sexual violence while cases of sexual violence in the past, whether due to domestic violence or the internal armed conflict (CAI), attend to peripheral clinics. In zone 7 most of the recent demand is related to domestic violence, while in zone 18 and zone 1 it is due to sexual violence, which is consistent with most legal accusations received as a result of sexual violence offenses.

The mobile unit has contributed a great deal in attracting patients with recent violence cases who went to the Attorney General's Office for help. It guarantees assistance coverage at times out of working schedule, provides transportation to the appropriate facilities (FS, GGM), and takes the victims who are referred to other services identified by the networks coordinated by MSF-CH. This service provides an immediate response to emergency calls of sexual violence at night or daybreak, helping with the demand of services in zone one and cases referred by the Attorney General's office. The mobile unit also has been strategic to handle confidentiality of cases because it reduces the stigma of SV survivors looking for help.

The mobile unit presents some problems of time coordination and space in the facilities of *Fundación de Sobrevivientes* (morning schedule) and *Grupo Guatemalteco de Mujeres* (afternoon schedule), which are inadequate, but should be addressed once the changes to San Juan de Dios are made.

It is urgent to improve the conditions and establish a location for medical and psychological consultation, to concentrate assistance in zone one. Obviously, despite the parties' support, the coordination of spaces with FS and GGM is not only insufficient but also inadequate.

In the meantime, on the basis of very limited time overlap between night shift staff and the rest of the team we do not consider it advisable to hire more technical staff to organize 24-hour services with calling shifts. This would imply a greater burden to MSF-CH's resources and capacities to maintain coherent, good practices.

Medical Assistance to Sexual Violence Victims

During the first medical consultation, the medical doctors focus on building the trust of the patient so as to be able to intervene. It is a matter of helping the patient to calm down, listening to the story with empathy while avoiding over victimization. Knowing there is a variety of emotional reaction to sexual violence, the medical doctors are very sensitive to providing a safe environment for patients to express themselves as they need. Then a medical evaluation is done, and if needed for any major injuries or suspicions a referral will be made to Roosevelt hospital.

Samples are taken and diagnostic tests are done for STIs including HIV/AIDs,, as well previous pregnancy is ruled out. Depending on the timing of the case and analysis of the medical doctor, the medical intervention can include morning after

pill, post exposure prophylaxis for HIV/AIDs, HepB vaccination, Tetanus toxoid, etc. etc, anti nausea medication, and antibiotics if required. Any treatments are accompanied with patient education, and follow up visits are organized at the end, along with confirming that the patient is connected to the rest of the MSF services

Administratively, patient forms are also filled out by the medical staff, patients are asked to sign consent forms, and informed of their possibility to launch legal proceedings. For any security issues, the patients are referred to the CAIMUS for shelter purposes.

There is a strong consensus both internally and externally, about the fact that “national staff should not be involved in legal proceedings” as an effective protective measure. MSF-CH’s role of assistance has been defined, as well as the referral process if the victim is willing to file an accusation. The legal accompanying process must be carried out by institutions that have no presence in the community in order to prevent any reprisals from the aggressors.

With regards to medical certificates, only the certificate issued by the INACIF serves as legal evidence, and this relieves the team from legal responsibilities when patients initiate due process. In the absence of this certificate and only in favor of the legal process of the victim, information in the dossier can be shared, provided that the victim gives express authorization. We recommend discussing with the team the decision on each specific case.

For patients not attending the Attorney General’s Office, we suggest MSF-CH could complete the certificates and securely keep them without a seal for a limited time. The certificate could be destroyed if the patient does not claim it in due time. Due to the complexities of making these documents official by Guatemalan standards, the proper seals could then be affixed whenever the patient requests the certificate in order to initiate a legal process. However, this issue is extremely

sensitive in terms of exposure of the staff, and more discussion about the nuances of this are required before deciding to proceed.

The team detected weaknesses in the system of recording the cases which needed to be improved; the team suggested that it was necessary collaborate with the MOH statistics to visualize the problem and support the integration of the service in the future, according to the cases demanding assistance.

Psychological Assistance to Sexual Violence Victims

It was noted that the earliest/older cases of violence show more PTSD symptoms than the recent ones. As time elapses without receiving psychological help, reinforces the traumatic structure and symptoms become chronic. The earliest cases of violence required more than five sessions, with as many as ten sessions reported to date. The complication is the addition of experiences of violence lived by the victim. You get rid of one and other appears; furthermore, daily problems and family relation issues arise. Recent violence cases had better prognoses as long as there was social support. These cases are assisted with short and urgent therapies in a sequence of around five sessions.

70% of cases present multiple violence stories, including physical injuries. A minimum percentage of the identified victims have rejected psychological help or have discontinued the treatment after one or two sessions. Another important observation was that the most successful recuperation was produced when there was social support (family, friends, and neighbors). The social aspect of the SV victim causes more impact than the trauma.

In the clinics the team is not actively encouraging the victim to file a report of the case, but in the event that the victim requests legal assistance, information about the procedure is provided: then, the patient is referred to the most suitable organization (considering location or previous knowledge). For those seeking

legal process, it has been noted that more sessions are needed to provide the support necessary for the patient to proceed.

It has been noted by the team that emotional recovery proved to empower the patient about their rights and in some cases motivated the patient to seek legal proceedings during psychological care. This is seen as a positive result in the model of integral assistance being implemented.

The first psychological consultation explores "how do you feel about what happened?" The work focuses emotional blocking and not feeling guilty. Some indicators of psychological help used in the sessions include overcoming resignation and worthlessness, as well as building empowerment.

As a means of strengthening social support, self-help groups have been also started in the project recently. The exchange of experiences is encouraged in these groups to give a new dimension to the incident with other perspectives: "It not only happened to me." Seven to ten women form the groups and voluntarily join when the women are emotionally stabilized after receiving psychological first aid. The ground rules of the self help groups include: a) confidentiality; b) respect; c) mutual support, and d) punctuality. The groups meet every two weeks for a two-hour session. The participants include women who feel comfortable speaking before others about their situation. Some constraints were starting to arise out of this new activity which require attention, such as a) Women's irregular participation in groups; b) Needs arising from poverty of financially vulnerable women (in zones 7 and 18); and c) the presence of children who obstruct the group activity. Otherwise, the groups function to help those affected face their trauma with more dignity and strength to move forward.

The number of sessions and resulting intensity of the work related to the extended role of the Psychologists in helping patients work through their traumas means there is a heavier work load per patient for the psychologists compared to the

medical staff. The psychologists assist a daily average of six cases, which is excessive. Although the team is aware of the issue, and some adjustments were being made, it is anticipated that more psychology staff will be needed in the future to distribute the case load.

At the peripheral clinic of zone 18 there is a coordinated activity and victims are referred to psychiatric consultation subject to the complex nature of the case or the eventual need of medication. The monthly average of referrals goes from 1 to 3 cases, although it increased during early 2009 from 6 to 9 cases in January, especially due to posttraumatic stress and depression as a result of previous violence cases with chronic symptoms. The established coordination has been favorably evaluated as well as the project strategies because “the awareness achieved to attract affected women is appropriate and causes a social impact, which is evident by the increase of the demand of clinical assistance and the legal report of cases.”

As a result, there is mutual cooperation between MSF-CH psychologists and the MOH psychiatrist, and the cases referred are assisted. “If there is no progress during the third session, the psychologist refers the case to the psychiatrist.” This also helps to keep the appropriate capacity of response and prevent overwork due to unmanageable demand.

Role of the Attorney General’s office supporting the victims to file a report

The law on femicide approved in 2008 binds hospital staff to file a report every time a victim of sexual violation is assisted. However, institutional health staff is not willing to be involved with the legal procedure, as hospital staff fears any consequences and threats from the aggressors.

There is a derivative network that gathers more than 65 NGOs, GOs, Communities, and International Cooperation agencies that work on sexual violence issues and work as a collaborative link between the Attorney General's office and civil society organizations (FS, CICAM, GGM, New Horizons, and Executive Committee of Justice). The objective of this derivative network is to facilitate referrals for assistance and integral recovery of the victim. Having access to this network, it is possible to better access patients, and make referrals for cases requiring services beyond the medical/psychological support.

Collaboration Levels between MSF-CH and the Attorney General's Office

An agreement has been signed between MSF-CH and the Attorney General's office to facilitate integral assistance to the victim through direct access or referral to psycho-social and forensic evaluations, as well as the filing of legal accusation. "MSF-CH persistently struggled to create this alliance; although the Attorney General's office is a closed, unapproachable bureaucratic institution, MSF-CH manages to obtain their collaboration, which helps to prevent over-victimization. MSF-CH's presence at the Attorney General's Office is achieved with three attending physicians with night shifts, and an additional doctor for weekend shifts. The objective is to cover the demand whenever the Office of assistance to the victim (OAV)/MP staff is not available.

The Attorney General's Office also refers cases to MSF-CH assisted by OAV but requiring more sessions of psychological support; this service is not rendered by psychologists from the Attorney General's office.

Steps of Victim Assistance at the Attorney General's Office

1. File the accusation and take deposition.
2. Forensic evaluation

3. Medical evaluation and MSF-CH tests. Preparing a dossier (medical information and summary of events). Next appointment.
4. Psychological assistance from MSF-CH. Coordination with physicians in order to have both consultations the same day.

Some information is orally shared, including the results of forensic evaluations made by INACIF (located within MP's premises) whenever the victim files an accusation before the Office of Assistance to the Victim, (OAV). The MP also shares with MSF-CH statistic information regarding legal accusations filed by the victims. "Coordination between MSF-CH and MP has scored a win by accepting an external physician to evaluate the victim and give her emergency treatment."

MSF-CH's collaboration with the MP has caused internal controversy and reserve in the organization. In November 2008, the study included how this collaboration process was perceived, this was also checked in interviews during this evaluation. In general, on a perception basis, MSF-CH's legitimacy and credibility is valued as an international Actor, capable of forcing internal changes to achieve a complete and respectful assistance to the victims reporting their case. In terms of independence of decision making, this is also intact. The MSF Clinic within the MP function quite independently. One cause for concern noted is that the MP requires the forensic evaluation prior to providing prophylactic medications. Under these circumstances some patients are delayed for some hours. For this purpose, communication between the MP and MSF-CH is important and necessary. This has been expressed as a concern for those in the MP, and will need to be diplomatically balanced with MSF's own need for independence.

"It is better if MSF-CH relates with the Attorney General's office; it is an acknowledged Actor and receives more attention than national NGOs". (MOH) "The functional independence of MSF-CH pushes toward good quality service" (CICAM). Opinions gathered support that the presence of MSF-CH within the MP's premises neither look threatening nor create distrust in the victims. On the

contrary, it implies an external and auxiliary support to meet the victim's needs, with the advantage of being a controlling external eye, as seen by the Civil Society organizations. For that reason, it is valued that "it is an accurate strategy to focus on the rehabilitation and derivation by cooperating with other strategic actors. It could lose effectiveness if it provides legal support. For that purpose there are other cooperating NGOs." (PNSM).

In terms of the MP's perspective, they satisfactorily evaluate the relation between MSF and the MP. However, there is the concern about communication and extent of coordination. Although from an MSF perspective this can be seen positively in the sense the team has kept their distance, without losing independent function it would be good to consider holding periodical exchange meetings with the MP teams, while extending the relation and communication with the *Fiscalía de la Mujer* (Woman's Attorney's Office).

The communication tension noted by the MP reflects the fear and resistance of public officers to the external institutional interference by an international Actor. For that purpose it has been suggested to reinforce discussions with the MP staff to reduce tensions. The discussion can focus on making clear to the corresponding officers what is MSF-CH's position and operation and why does it help in a moment of institutional crisis and limited resources to improve victims' assistance.

Record of Cases

Even though there is some "dance of the figures" regarding the actual dimension of the issues of sexual violence which translates into a lack of consistency and with that allows for no systematized information, the figures suggest the seriousness and recurrence of different types of sexual violence against women as a national emergency. The Ministry of Health, the Attorney General's Office, and the

National Civil Police have jointly reported more than 4000 cases of violations and sexual offenses between January and October 2008.

In 2007, the Attorney General's office received an average of 70 monthly SV reports, in the five offices opened within the Metropolitan area. In 2008, the monthly average increased to 90 reports since the beginning of the year. In general terms, the growing demand of assistance is accompanied by an increase in the victims' capacity of reporting the facts. We have known about new cases that motivate filing a legal report, like the case of a young lady who, before 40 of her neighbors, how she was raped three months ago by two notorious gang members in the neighborhood.

The Project shows impact results through the record of cases. During a year and a half, more than 400 cases have been assisted. "In 2008 the peripheral clinic of zone 18 has assisted 420 cases, 310 of which have been assisted during the last six months."

MP-OAV	PC zone 18	PC zone 7	Mobile Unit Zone 1	Totals
December 08: 31 case	December 08: 20 cases	December 08: 19 cases	December 08: 13 cases	More than 400 cases assisted May 2007 to December 2008
January 2009: A total of 83 new cases assisted in four services opened				

MSF-CH has a systematic record of cases that has been made public during the meetings held twice a month with teams from each clinic; the record has been kept by the coordinating physician, who transfers the information to the MSF-CH's headquarters in Geneva. This record is systematized with the purpose of contributing internationally to visualize the phenomenon of sexual violence in the whole world. It is also shared with Guatemalan NGOs and GOs with which MSF-CH collaborates, regarding the referrals or derivations of cases to achieve a more

integral assistance to the victims. The value of breaking the silence on SV and making people aware about its effects, allows for new cases to receive assistance, reduces the resistance, and gives space for more scope in meeting victims needs.

In 2003 the first SV cases were detected and up to 2008 there have been 1101 cases assisted in the clinics of Roosevelt Hospital. This means that “when the service is open the people come because they need it.” (MOH).

It is advisable that the whole team of MSF-CH know the record of cases, so the meaning of these indicators may be discussed during the meetings, the technical team may be aware of what is happening in the country with these problems and what it is influencing the Project to improve the needs of the affected women. The collective appropriation of these data enables a deep approach to the scope and effectiveness of the intervention that is carried out.

Another identified problem is the need of unifying the medical and psychological information of each patient in a single file. To share this information it would be advantageous to have a whole vision of the needs and evolution in the patient's rehabilitation process; but the MSF-CH team has identified operational difficulties to access and guarantee a discreet handling of the dossier, if handled jointly as well. It is recommended that the dossier does not identify the victim by her name in order to avoid possible reprisals. It is suggested to codify the names and keep the lists confidential.

It is important to mention the estimated figures of sexual violence in zone 18 reach between 8 and 10% of the population, and anxiety and depression disorders reach the 40%⁵ of women, most of which have suffered incest or sexual violence in their background.

⁵ Data of psychiatric consultation at the zone 18 Peripheral Clinic. Dr. Reinse.

Generally, better data collection and more research on the epidemiology of sexual violence and its impact are needed. One study is being organized between MoH staff and MSF, this initiative is supported and should receive continued backing from MSF CH.

6. SOCIAL NETWORKS AND STRATEGIC ALLIANCES

MSF-CH works in alliances with networks of Civil Society and government organizations focused on the knowledge, abolition, and prevention of Violence against Women. The networks handle the political game and face different positions and interests. The role of MSF-CH is to coordinate with them to gain from the benefits of the alliance without getting into political agreements. This dynamic allows keeping MSF-CH's independent position consistent with its acknowledged international role, while pragmatically benefitting from the alliance on an operational basis. As well, there is a "Strength in numbers" effect that MSF-CH benefits from which feeds into minimizing risks while participating in broader impacts.

Levels of alliance and collaboration given in the Project

- a) Coordination with NGOs from Civil Society for referrals.
 - Legal advice and accompaniment to victims: *Fundación de Sobrevivientes*.
 - Derivation to *CENTROS DE ATENCION INTEGRAL A MUJERES (CAIMUS)*, *FUNDACION SOBREVIVIENTES (FS)*, *GRUPO GUATEMALTECO DE MUJERES (GGM)* and *APROFAM*.
- b) Coordination to share spaces of assistance to victims. Clinic of psychological assistance at *GRUPO GUATEMALTECO DE MUJERES*. Due to the inadequacy and limitations of space the negotiations for the opening of a service of assistance in the Health Center of zone 1 must be held.
- c) Coordination in networks for the knowledge of problems and the needs of assistance in sexual violence cases, through the participation of MSF-CH in exchanges and discussions with NGOs, GOs, and government authorities. *PROGRAMA DE PREVENCION DE LA VIOLENCIA (PROPEVI)*, *DEFENSORIA DE LA MUJER INDIGENA (DEMI)*.
- d) Coordination with NGOs and GOs to refer assistance of specific cases: assistance to underage victims referred to *MISION INTERNACIONAL DE JUSTICIA*. Clinical assistance for the treatment of HIV-AIDS in sexual diversity cases

(homosexuals and prostitutes): *FUNDACION MARCO ANTONIO*. They assist an average of one to two monthly cases. MSF-CH contributes by providing medical kits to sexual violence victims. *CLINICA APOYAME* handles a network of 27 public and private organizations which refer victims to the centers of assistance and update information regarding the issues exchanged within the system.

Most external actors acknowledge that it was not until mid 2008 that it was clear what MSF CH was doing in sexual violence. Since, their impact is much more evident. All external Actors point out that MSF-CH has a high level of credibility and is a positive international reference in the country to contribute with the support of a model of integral assistance for sexual violence victims. They all agree that it is necessary to keep the support and communication with the Civil Society network, focusing the technical role on accompaniment, support and facilitation of health assistance procedures, clinical assistance, and the record of cases, in order to portray SV issues to health authorities while leaving to local NGOs the role of social pronouncement of the issue. "Many NGOs feel supported, the patients have a different life opportunity, and the Ministry of Health is forced to give and answer" (CICAM).

"The strategy of being within the health institutions' or the MP's facilities forces them to institutionalize the service creating the favorable conditions through the equipment of clinics, supplying medicines, and training and specializing a staff that is more sensitive to these problems. "This has meant a bridge-like strategy for the government to assume that something needs to be done." (CICAM).

For the purpose of institutionalizing SV issues it is suggested to repeat the same strategy used to open the HIV clinic at Roosevelt Hospital: support with supplies for the functioning of the clinics; continued lobbying, in order to have the service included in the hospital budget; lean on potential allies such as the *Clinica Adolescente*, *Planificación Familiar* and *VIH-SIT* Programs, for the lobbying to

achieve the opening of the service at San Juan de Dios Hospital and the future integration to the health system.

The two more significant precedents have been “MSF-CH’s international pressure to strengthen institutional policies regarding victim’s protection and rehabilitation, and the fact of becoming a model of integral assistance with no parallel in Central America”.

Working as a network and keeping specific alliances implies some organizational challenges to improve the handling of patients received at the MP and the Mobile Unit. This promotes additional mutual support relations among the organizations involved.

The mobile unit does not render the service directly but takes patients to the clinics of reference in zone one of the capital city (*Clínica del Grupo Guatemalteco de Mujeres –GGM*) that has been lent to MSF-CH as a support infrastructure for medical and psychological attention of cases. Nevertheless, the space provided is inadequate due to the demand received in both institutions which has forced the need of looking for a temporary solution while negotiating the opening of the service in the outpatient care unit of Hospital San Juan de Dios located downtown in the Capital city.

MSF-CH coordinates with the network of shelters for victims managed by Centros de Atención Integral a Mujeres Sobrevivientes (Centers for Integral Assistance of Survivors) (CAIMUS). These centers are already approved by the Law of Femicide which has allocated resources for their implementation in 2009 with a mixed budget (Government and CI). The CAIMUS respond to the strategy of security for women affected by violence and the objective is that their opening will serve as a pressure to institutionalize this model of assistance nationwide. Assistance is provided to SV and domestic violence cases involving women and children under

12. The cooperation agreed between MSF-CH and the CAIMUS includes referrals and counter-referrals for the legal, social, and psychological counseling services.

A practical limitation for referring to shelters (CAIMUS) is that they do not always meet to the demand of referrals due to the lack of adequate spaces. Besides, the transfer to these centers is very complicated due to the security measures that must be taken to protect the victims.

Although MSF-CH has good contacts, it was noted that on a more purely medical basis more could be done with external actors. One possibility is to strengthen MSF-CH's alliances with the Pan American Health Organization to make further pressure in breaking the silence regarding this issue and portray the seriousness and increasing significance of sexual violence in Guatemala, and the emerging needs of assistance (teenagers and girls).

A number of external actors suggested that the project should be connected with CONAPREVI which advises NGOs on SV issues and has an influence in the health sector. This could be another way of opening new doors for communication and institutional relation.

In conclusion, MSF-CH is still making adjustments to improve the necessary coordination with collaborating national NGOs (GGM and FS) and reorganizing the transfer of victims from the mobile unit in a more functional way. The role of the network is to coordinate the referrals assuring integral assistance, share common challenges in the approach of issues, and immerse into the knowledge of the context of violence and impunity. MSF-CH participates and must continue participating in the Civil Society network involved in sexual violence issues from a political perspective and in the integral assistance to female victims. The joint strategy is to join coordinated efforts and guarantee actions of good practice in the rendering of public and private services.

7. INSTALLED CAPACITY OF MSF-CH

The MSF-CH team in Guatemala is formed by 31 members (January 2009), 12 of which are professionals: physicians, psychologists, nurses, and social workers for the integral clinical assistance of sexual violence victims. Nowadays all technicians are Guatemalan, save for the Mission Coordinator and the Medical Coordinator, who are expatriate foreigners.

In a project of this nature the Guatemalan identity of professionals assures shared cultural codes, which are indispensable for carrying out rehabilitation work with violence victims. The hiring of national staff and the fact that the technicians are all women have been strategic elements to implement the Project. "The strategy of hiring national staff was positive due to the levels of confidentiality in a context of risk and effectiveness to achieve the impact." (PNSM).

It has been noted that the working environment of the teams is respectful and acceptably integrated ("We make great efforts, because we like our job and we believe on what we are doing"), attempting to achieve interdisciplinary coordination consistent with the victims' interests. An added value is that the team has working experience with national and international NGOs, technical capacity and professional experience.

At the beginning, there were tensions and adjustments which are typical while multidisciplinary teams incorporate; however, there is currently a favorable team environment and they share the decision of strengthening the teams facing the new challenges at work. There are three particular challenges at the time of facing external pressure:

- a) Valuation of risk (possible reprisals from aggressors, victim's vulnerabilities)
- b) Needs and measures to protect the victims.
- c) High risk cases (for example, prostitution networks owned by members of the gangs etc involved in illegal businesses.)

The technical teams gather at the office in the afternoon for the informal exchange on the daily challenges of work. This time and space is valued and improving the atmosphere of the staff. We believe that it not necessary to regulate this exchange in order not to place the spontaneous exchange opportunities lived by the teams into a bureaucratic scheme.

Dynamics of Operating

The process of reorganization is being consolidated with the change of strategy that promoted the launching of the project. This reorganization has required an intense dynamic of meetings to assure the operation and the work areas had to be subject to the actual context, in order to understand the specific demands and issues at each location (levels of poverty, types of violence, accessible and reliable agents and local leaders, objective risks, and protective strategies). “We are making efforts and taking steps that move us toward a multidisciplinary integration of teams, which has reduced tension and competition between physicians and psychologists.” The social division of professional bodies in Guatemala is quite rigid and unequal. There is no teamwork culture and there is rivalry and distrust between physicians and psychologists, arising from ignoring the competence and abilities of the others. Natural inter-professional alliances tend to reproduce between psychologists and social workers on one side, and between doctors and nurses on the other. The complete integration of the team still needs to develop more.

Coordination is still required to have physicians understand and discuss mental health as a priority along with medical treatment. Mental health is starting to uncover due to the increase of suicide and depression cases in the population. As communication increases, rivalries between professions disappear. Instead, professionals complement their knowledge with other fields of interest, which is useful to face the challenges of complex cases. The opinion on psychological

assistance has to be underlined because it is an unfamiliar matter and a less valued professional practice in Guatemala.

Professional Development

Generally, the requirement in Guatemala is that the Institution provides the space and the opportunities of training, and that each applicant responds according to his or her interests and needs as there are different levels of experience and knowledge. This needs consideration by MSF in national staff policies.

For the clinical supervision of the cases, an interdisciplinary discussion of the cases is being held with all the team in each zone. However, the specificity of educational needs in addition to the new challenges at work suggest it is better to strengthen education and training of physicians and psychologists, separately in the first instance.

It is recommended to separate the supervision of clinical cases by professional sectors (psychologists, physicians, social workers, nurses) at an initial phase, in order to assure the capacity installed (knowledge, techniques, tools) and the exchange within a professional sector. This dynamic is compatible with the holding of meetings of the interdisciplinary team, by zone, twice a month, with the strategy of gradually converging into the discussion of complex clinical cases by the entire multidisciplinary team; but technical tools for a good diagnostic and appropriate treatment must be consolidated first.

It is essential to establish a progressively interdisciplinary sequence of process in the discussion of cases. Since there is more synergy between psychologists and social workers, and between nurses and physicians, such cohesive factor must be considered an advantage. It is better to create the conditions for exchange between physicians and psychologists than impose it as an organizational

dynamic, which would cause resistance and distrust between teams and management.

Prevention and Risk Management

The MSF-CH team is aware that sexual violence is a highly sensitive issue and it faces risk management. Being a local team, the knowledge of the context and typical self-defense methods is strengthened. The team tries to avoid the problems that are not of its competence, keeping a balance between the need of protecting the victim and the working teams. This is well done because of the depth of local knowledge in the national team in combination with an openness to take on board staff understanding, knowledge and concerns by the international team. The team values the continuous reminding of the MSF-CH's security rules as a necessary and positive control to prevent unnecessary risks for the team. The handling of security is a consequence of this balanced against the situation, the insecure social environment, and the high impunity levels prevailing in the whole country.

Even though the premise is that "staying within the limits of health work minimizes risks regarding safety", we think it is better to take into consideration that the nature of the project determines a series of unavoidable but foreseeable risks that should not be denied, ignored or underestimated.

Reaction of the aggressors, impunity, and fear were repeatedly pointed out by all the consulted External Actors and points to eventual incidents particularly as MSF scales up and increases impact. This in combination with the random violent events that can befall team members, requires that MSF anticipate these situations with security measures, not only for the victims but also for the team.

Given the risk of the context and the resistance of the institutional health staff to work with sexual violence, the courage, strength, availability, and commitment of the team involved in the Project are enlightening.

Team's Self Care

The work is debilitating as it is satisfactory because of the challenges involved and the commitment required. "I am in this job because I feel useful, I feel happy when we get to give integral assistance; for me, this changes the life of a woman who will be able to succeed."

Each group within the MSF staff have different stressors related to their work which require intensified support. The medical staff have additional tensions related to the requirements for the initial medical emergency assistance, and the responsibilities and risks that accompany that. The psychologists face the extended relation with the patient during the recovery phase. Nurses and social workers also have a huge emotional overload in their job because they are the first to detect the cases and establish the first contacts. Other office staff face the strain of being exposed to the emotional traumas through supporting the medical team without necessarily having the professional training to deal with the emotional trauma that accompanies involvement with such a program.

The teams are aware of the emotional impact produced by working on sexual violence issues, for which MSF-CH has some protective measures available, such as the availability of private individual therapy for MSF staff, medical team case discussions, and periodic social events for staff.

To reinforce that the necessary care is provided to staff, there is a need to further follow up on "caring for the caregivers". Although, accessing psychological support measures is voluntary, and should not be an institutional imposition, MSF can take measures to open the possibilities. It is recommended that the process of accessing psychological support for staff needs to involve only external channels, thus bypassing the step of medical coordination approval which could block support on the basis of hierarchical relations. This will require a system between

the chosen psychologist(s), and MSF which assures appropriate use in combination with confidentiality.

Having spaces/time and team dynamics to share information about the psycho-social impact of working on sexual violence cases, and respect the MSF-CH's rule to necessarily rest every six months should also continue.

In terms of contract length for those regularly in contact with SV patients, as the project continues there will be a need to balance stability of the team with individual well being. It is advised to consolidate the integration and stability of the team if the members are willing to extend the contract. This will avoid continuous rotation of personnel, which is perceived by the victims as unsteadiness of the Project. Two years of work develop stability, but after that time workers jeopardize their mental health because of the nature of the job. Hence, after that term, rotation is advisable.

8. FINAL CONCLUSIONS

MSF is starting to have a very important impact on different levels. It not only includes intended effects of providing medical and psychological care for those accessing the services, but also feeds positively into addressing sexual violence on broader levels. Despite the many hurdles, in combination with a few other key organisations MSF is beginning to break the country's historic silence around sexual violence. The Project has proven to have an impact because there is a sustained increase of the demand of attention to cases. The services do take action by providing effective help and, in consequence, follow-up cases show very few defaults.

In terms of care provided, although there is a good impact on those accessing the services, it is clear that MSF has barely begun to provide treatment compared to the potential numbers of cases. Although exact percentages were not known, it was clear that a significant majority of cases do not have access to care. This is based on a number of factors including the individuals' understanding of violence, the willingness of health staff to provide treatment, and a very real fear of consequences related to judicial pressures along with impunity in the country. Despite the need for more services, the strength of this program is its focus on the specific zones and structures chosen to implement focused medical psychological support services.

As a result of the cooperation alliances with others national actors, the filing of accusation is increasing, which shows that the silence is being broken regarding this hidden and denied reality, as the record of cases also show a more precise dimension of the problems at metropolitan level and the urgency of extending the actors' response.

The strategy of presence and the collaboration with the Ministry of Health and the MP is an appropriate transitional policy in order to reach more patients. As a result of the relation and communication between MSF-CH and MOH a few behavioral

changes regarding prejudice and victim discrimination have been noticed on the part of MoH because of the inputs of MSF. Encouraged changes show a better communication and mutual support between MSF-CH and the staff of Health Centers.

According to this balance and taking into consideration the difficulties to negotiate the institutionalization of a Program and secure an interdisciplinary dynamic of work, consolidation is key to continued success.

The team is pushing itself in a manner that reflects a new and exciting project, the pace resembles that of an emergency. Long hours every day, working on weekends, Saturday meetings, etc. Although it is clear that the motivation and dedication for the work is strong, there is a concern that staff will not be able to keep the pace.

Risks are being well managed and minimised by the team, this is in part due to the strong national staff presence and inputs which allows for a more attuned understanding of the context, the underlying dynamics related to sexual violence.

The team has managed to develop a fine balance, the trick will be to maintain the direction in the event that the HoM and MedCo are moving on. It is advised that any replacements are given the opportunity to spend extra time in Guatemala to gain an understanding and receive a comprehensive handover.

Ideally, the project should be subject to a medium term planning to implement, consolidate and then extend the services. The objective is to assure the continuation of a sustainable, pertinent and effective quality service for the victims of sexual violence. Therefore, it is recommended to evaluate the results after three years and decide if goals have been sufficiently met before moving into a handover phase.

9. LIST OF RECOMMENDATIONS

1. *Once it becomes possible to work at the San Juan de Dios Hospital, MSF-CH's staff at the Attorney General's Office clinic should then move to the Hospital. This must be clear for the parties involved and the right time to leave the Attorney General's office should be estimated according to the existing needs at both, the Attorney General's Office and San Juan de Dios Hospital. It is important to keep good relations with the Attorney General's Office to enable the transfer of future cases from the Attorney General's Office to the hospital supported by MSF.*

2. *Nevertheless, in the interim it would be important to carefully monitor the extent of independent functioning and the perceptions with the external actors. It is clear that MSF-CH should not provide unrestricted support to the Attorney General's Office, not even supervise and verify the activities to be developed by the Attorney General's Office. MSF-CH should instead limit the work to the clinic and make sure that communication routes between the MSF-CH teams and the Attorney General's Office are adequate.*

3. *The future development of the project should be focused on the strengthening the chosen framework. It is not advisable to subsequently extend the project beyond what would be necessary to improve the access for patients in zones 7 and 18, the MP in the interim, and eventually San Juan de Dios Hospital. By limiting the intervention to these places, the team would have a better management of all the facts related to such a complicated and sensitive topic.*

4. *It is extremely important to keep working only in the medical field. MSF-CH could reach outstanding impact simply by choosing to provide medical and psychological assistance. Keeping this procedure would also minimize the security risks related to sexual violence intervention within the Guatemalan context while other organizations manage the other components of response.*

5. *It is very important to promote information, education and communication activities in order to increase awareness. However, the need of focusing activities to key groups instead of anyone who wants to listen is particularly evident. It would be valuable to identify key groups according to the resulting impact.*

6. *It is possible and advisable to launch a communication campaign on medical consequences of sexual violation, but only after the activities at San Juan de Dios Hospital have begun. It is essential to wait until the activities have been launched in the hospital due to an expected significant increase in the numbers of cases linked to the communications.*

7. *When communicating, the emphasis should be operationally based in the medical and psychological areas. Communications focused on the activities will help to augment MSF's access to those affected through building awareness, while minimizing risks associated with communicating on more sensitive matters and catalyzing greater change and impact.*

8. *The network of contacts is a crucial factor of the program. It assures an element of protection for the organization and staff consistent with the number of organizations involved with a very specific role. To this effect it is important that MSF-CH does not get involved in the legal aspect regarding minors or provide shelter to cases, but instead continues to refer the cases to other organizations which actually take charge of these components. The contacts within the network are well developed although there were some uncovered areas with regards to medical networking.*

9. *In order to strengthen the technical medical knowledge and the support, MSF-CH should consider playing a stronger medical role within the political network. Having the MSF-CH medical team already linked to the Ministry of health staff through the project, it is quite possible to create a strong and well*

empowered team that could continue and complete the work started by MSF-CH at the higher MoH levels.

10. Both the medical and psychology interventions are comprehensive in their respective protocols and procedures. The volume of work between the two disciplines is clearly different on the basis of patients' physical and psychological needs. The psychologists have a greater volume of work and the team is already making adjustments by recruiting more human resources; nevertheless it is easy to anticipate that more arrangements would be needed in the future with the psychologists to keep an adequate workload to allow for continued quality support. In addition, it is anticipated that more MSF staff will be required for the San Juan de Dios hospital beyond what has been expected. It is recommended that planning integrates these staffing needs.

11. In terms of professional supervision for the medical and psychological staff, we suggest supervising the medical team on two levels: at the beginning according to the specialty in order to build up capacities, and later in an interdisciplinary manner in order to benefit from synergistic interactions and assure comprehensive care.

12. To protect the team from burnout we suggest that the meetings take place during regular working hours, although this would imply leaving the clinic earlier once a week. Working overtime should be an individual choice, and not structured so as to give space to those needing time off to recuperate.

13. Even though the security risks are well handled and minimized by the team, it is clear that problems with threats would occur at some point due to the nature of sexual violence within the context of Guatemala. With that, MSF-CH should keep a high level of attention to security management and always be ready to handle the possible threats.

14. *Although the project started in 2007, it only began to show significant steps forward about six months prior to the evaluation. It is necessary to take this into consideration when establishing the duration of the intervention. We suggest that the project be planned for the next three years for consolidation and followed by a handover phase of two years. With this timeframe, it is anticipated that MSF-CH would have an sufficient impact over the lives of many patients and the general situation of sexual violence in Guatemala⁶.*

15. *"This strategy of opening services inside the system is an important precedent, so it will not be easily closed following handover." Although MSF-CH has had success with this in the past, it is important to keep in mind that several health programs have been opened with the support of other international cooperation efforts and then closed afterwards due to the incapacity of the Guatemalan government to integrate the service, even if there was a high demand from people for the services. It is elements such as this, which highlights the need for a protracted timeframe in the implementation phase which should include comprehensive negotiations, agreements, and inputs around handover, along with an extended handover phase to reach success.*

16. *Whether part of MSF's own policies or not, the team is facing the living history of the country as a result of sinister practices from the past and its effects on the society. Within the health system there are those who collaborated with repression, and currently oppose the renewal of the Sexual Violence Protocol and provide assistance at public health centers. Therefore, it is recommended to "involve teams in understanding the context and violence cycles, standardize the type of approach regarding the assistance model, guarantee supervision by the review of practical cases, and the emotional impact caused on psychologists." (PNSM). This allows a greater understanding of the broader impact to which MSF contributes.*

⁶ The external evaluator suggested 10 years was more appropriate timeframe, however taking into consideration the dynamic and planning cycles of MSF the timeframe suggested was compromised to that recommended in the report.

17. *Although there is an informal openness to see any case that presents to reduce stigma, it is questioned if MSF should formally branch into general violence cases, as the Guatemala system is well set up for general violence medical response (gun shot wounds etc).*

18. *The work of awareness and education must be gradually extended to contribute in changing the mentality of resistance, starting from the health service itself and the Health Ministry officers. The recent accusation filed by an elder lady raped by a doctor, involved the complicity of the Attorney General's office itself, whose officers made fun of her while she was undertaking the corresponding procedures. "So what? The lady is not bad at all!" This type of offensive and cruel comments deserves efforts to achieve awareness and respect and change the mentality of public officers. This is the type of offense that the victims must face in their way of looking for repairing help and file an accusation. We suggest that this work can be extended to educational courses together with the staff of the centers where the services are rendered.*

19. *It is important to push for the approval of the new Sexual Violence Protocol because of the professional need to have available tools which promote more current practices with an appropriate perspective. There are new challenges in the approach of these issues and it is advisable to strengthen the specialized training of the technical team along with advocating for the protocol.*

20. *It is recommended to consider incorporating preventive work with the community through information and education for change. This need has been identified because sexual violence takes place within families, marriages, group of friends, and is associated to machismo and the culture of violence. Although preventive work does not visualize the results at a short term, it is more effective to bring indicators down and reduce social impact. Awareness campaigns for looking for help and educate to prevent violence are compatible. The educational*

messages can be integrated to promotional campaigns performed by MSF-CH in association with other public and private actors. The extent to which MSF CH is willing to engage in prevention, however, will depend on the overall operational policy.

21. *It is urgent to improve the conditions and establish a location for medical and psychological consultation, to concentrate assistance in zone one. Obviously, despite the parties' support, the coordination of spaces with FS and GGM is not only insufficient but also inadequate.*

22. *In the meantime, on the basis of very limited time overlap between night shift staff and the rest of the team we do not consider it advisable to hire more technical staff to organize 24-hour services with calling shifts. This would imply a greater burden to MSF-CH's resources and capacities to maintain coherent, good practices.*

23. *With regards to medical certificates, only the certificate issued by the INACIF serves as legal evidence, and this relieves the team from legal responsibilities when patients initiate due process. In the absence of this certificate and only in favor of the legal process of the victim, information in the dossier can be shared, provided that the victim gives express authorization. We recommend discussing with the team the decision on each specific case.*

24. *For patients not attending the Attorney General's Office, we suggest MSF-CH could complete the certificates and securely keep them without a seal for a limited time. The certificate could be destroyed if the patient does not claim it in due time. Due to the complexities of making these documents official by Guatemalan standards, the proper seals could then be affixed whenever the patient requests the certificate in order to initiate a legal process. However, this issue is extremely sensitive in terms of exposure of the staff, and more discussion about the nuances of this are required before deciding to proceed.*

25. *The communication tension noted by the MP reflects the fear and resistance of public officers to the external institutional interference by an international Actor. For that purpose it has been suggested to reinforce discussions with the MP staff to reduce tensions. The discussion can focus on making clear to the corresponding officers what is MSF-CH's position and operation and why does it help in a moment of institutional crisis and limited resources to improve victims' assistance.*

26. *It is advisable that the whole team of MSF-CH know the record of cases, so the meaning of these indicators may be discussed during the meetings, the technical team may be aware of what is happening in the country with these problems and what it is influencing the Project to improve the needs of the affected women. The collective appropriation of these data enables a deep approach to the scope and effectiveness of the intervention that is carried out.*

27. *Another identified problem is the need of unifying the medical and psychological information of each patient in a single file. To share this information it would be advantageous to have a whole vision of the needs and evolution in the patient's rehabilitation process; but the MSF-CH team has identified operational difficulties to access and guarantee a discreet handling of the dossier, if handled jointly as well. It is recommended that the dossier does not identify the victim by her name in order to avoid possible reprisals. It is suggested to codify the names and keep the lists confidential.*

28. *Generally, better data collection and more research on the epidemiology of sexual violence and its impact are needed. One study is being organized between MoH staff and MSF, this initiative is supported and should receive continued backing from MSF CH.*

29. *Although MSF-CH has good contacts, it was noted that on a more purely medical basis more could be done with external actors. One possibility is to strengthen MSF-CH's alliances with the Pan American Health Organization to make further pressure in breaking the silence regarding this issue and portray the seriousness and increasing significance of sexual violence in Guatemala, and the emerging needs of assistance (teenagers and girls).*

30. *A number of external actors suggested that the project should be connected with CONAPREVI which advises NGOs on SV issues and has an influence in the health sector. This could be another way of opening new doors for communication and institutional relation.*

31. *For the clinical supervision of the cases, an interdisciplinary discussion of the cases is being held with all the team in each zone. However, the specificity of educational needs in addition to the new challenges at work suggest it is better to strengthen education and training of physicians and psychologists, separately in the first instance.*

32. *It is recommended to separate the supervision of clinical cases by professional sectors (psychologists, physicians, social workers, nurses) at an initial phase, in order to assure the capacity installed (knowledge, techniques, tools) and the exchange within a professional sector. This dynamic is compatible with the holding of meetings of the interdisciplinary team, by zone, twice a month, with the strategy of gradually converging into the discussion of complex clinical cases by the entire multidisciplinary team; but technical tools for a good diagnostic and appropriate treatment must be consolidated first.*

33. *It is essential is to establish a progressively interdisciplinary sequence of process in the discussion of cases. Since there is more synergy between psychologists and social workers, and between nurses and physicians, such*

cohesive factor must be considered an advantage. It is better to create the conditions for exchange between physicians and psychologists than impose it as an organizational dynamic, which would cause resistance and distrust between teams and management.

34. *To reinforce that the necessary care is provided to staff, there is a need to further follow up on “caring for the caregivers”. Although, accessing psychological support measures is voluntary, and should not be an institutional imposition, MSF can take measures to open the possibilities. It is recommended that the process of accessing psychological support for staff needs to involve only external channels, thus bypassing the step of medical coordination approval which could block support on the basis of hierarchical relations. This will require a system between the chosen psychologist(s), and MSF which assures appropriate use in combination with confidentiality.*

35. *In terms of contract length for those regularly in contact with SV patients, as the project continues there will be a need to balance stability of the team with individual well being. It is advised to consolidate the integration and stability of the team if the members are willing to extend the contract. This will avoid continuous rotation of personnel, which is perceived by the victims as unsteadiness of the Project. Two years of work develop stability, but after that time workers jeopardize their mental health because of the nature of the job. Hence, after that term, rotation is advisable.*

Annex – 1

Terms of Reference

1. What is the added value of MSF-CH in addressing the problem of sexual violence in Guatemala city?

Basically this is to analyse and comment on the relevance of MSF playing the role they play in this context and in response to the particular problems/needs.

- Review initial needs assessment whether those needs are being addressed with current objectives and strategies.
- What is the advantage/disadvantage of MSF-CH as an international, medical, humanitarian organization (with its history in Guatemala) to work in this particular field?
- Who else is addressing the problems of sexual violence? What are the overlaps and/or synergies?
- How is MSF-CHs work perceived by the different stakeholders?

2. What is the potential impact of the MSF project on the level of i) the individual, ii) the public medical structures and iii) the NGO network, in terms of medical and psychological care for SSV.

- What has changed or what is changing on these three levels? – as perceived by the key people (the SSV, the employees, key informants, etc.).
- Are there any structural or process changes in the public and private services for SSV that can be related to MSF's presence?

3. How appropriate is the strategy chosen in order to reach the objectives? What is the risk of losing independence while working closely in a network of NGOs?

- How does the current strategy (components to be defined / described, e.g. choice of partner organizations, choice of priorities, staff, set-up, etc.) help or hinder reaching the objectives set?
- Address concerns of losing independence?

4. How do the project investments compare to outcomes (and to current and expected impact on beneficiaries)?

- Are there any obvious areas where efficiency could be increased? If possible review major expense items and assess relevance...

Annex – 2

Interviews

WITH THE STAFF OF MSF-CH

MSF-CH Teams	Position	Date, Place
Fabio Forgione	Mission Coordinator in Guatemala	Previous Contact (Dec. 08) Organization agenda and debriefing (130109) Preliminary conclusions: 220109
Alison Jones	Medical Coordinator	Office (January 12, 09)
Alejandra Perez	IEC supervisor	Marilyn
Antonio	Driver, (law expert! of project)	City (150109)
Aura Marina	Doctor, Clinic Z.18	L-M, 150109
Flori Piche	Financial Coordinator	Office (January 12, 09) L- M
Jaime	Logistical Coordinator	Luisa, City (140109)
Ana	Doctor for night shift MP	Marilyn – MP (night shift)
Marisol Rodas	Psychologist, C. Z. 18	L, C. P. Z. 18 (200109)
Mayra Rodas	Psychologist, C.P. Z. 7	L- 210109
Miriam	Social Worker, Z. 18	L-210109
Silvia	Doctor for weekends	Marilyn
Silvia Ramírez	Psychologist, Z1 (GGM)	Luisa, Office (190109)
Susana Pérez	Nurse, Educator, C.P. Z.18	M-200109
Yadira	Doctor, C.P. Z. 7	L-M 140109
Staff MSF-CH	Debriefing Team	220109

WITH ORGANIZATIONS AND AUTHORITIES

Organization	Representative	Date, Place
Ministerio Público	Clínicas MSF-CH	130109
Ministerio Público	Dinora Morales: liaison Attorney General's Office-Civil Society Jesús Hurtado – Metropolitan Area Coordinator, Oficina Atención a la Víctima	140109
Clínica Periférica Z. 18	Psychiatrist	150109
Fundación Sobrevivientes	Claudia González	150109
GGM	Giovanna Lemus-Coordinator	160109
Clinicas VIH-ITS Hospital Roosevelt	Dra. Virginia Gularte -	160109
Clínica Apoyame	Quetzalí Cerezo (General, Coordinator) doctor-nurse)	160109
Programa VIH-STI	Natl. Director of Program Mariel Castro	190109
Misión Justicia Internacional	Director – Pablo Villeda	200109
Hospital Roosevelt:	Psychiatrist – Alejandra Flores (former PNSM Coordinator)	200109
CICAM	National Coordinator and technical team	210109

Annex – 3

Strategic contributions of the MSF CH SV project

Strategic contributions of the MSF-CH SV Project ⁷	
<ol style="list-style-type: none"> 1. Publicly reveal and speak countrywide about sexual violence issues. 2. Socialize indicators of SV issues by keeping statistical record of assisted cases. 3. The Project is well focused on providing services of medical and psychological rehabilitation. 4. Efficient and qualified service assistance. 5. Implement a model of integral assistance to the victims through referrals and alliances with other organizations and entities. 6. High valuation to achieve collaboration from the MOH and the Attorney General's Office. 7. Necessary and positive contribution in addition to national efforts to fight against sexual violence. 	<p>Added values of the impact</p> <p>"Provide services to poor women, to those needier."</p> <p>"The strategy of providing medical and psychological rehabilitation services to the victims is positive; the team shall make no political pronouncement but shall incorporate to the existing social networks."</p> <p>"Psychological rehabilitation work has positive effects in empowering the rights of women, allowing them to make decisions and heal their trauma."</p> <p>"Empowerment contributes to relieve the victims' guilt and shame, encouraging them to look for professional help."</p>

⁷ Summary of evaluations collected by the MSF-CH team and staff from the Health System.

Annex - 4
Abbreviations

CAI	Conflicto Armado Interno	Internal Armed Conflict
CAIMUS	Centros de Apoyo Integral para Mujeres Sobrevivientes de Violencia Intrafamiliar	Integrated support Centre for (female) victims of domestic violence
CICAM	Centro de Investigación , Capacitación y Apoyo a la Mujer	Centre of investigation , help and support for women
CONAPREVI	Coordinadora Nacional para la Prevención de la Violencia Intrafamiliar y contra la Mujer	National Coordinator for the prevention of domestic violence and violence against women
CP	Clínica Periférica	Peripheral Clinic
DEMI	Defensoría de la Mujer Indígena	Centre for the defence of the interests of indigenous women
FS	Fundación Sobrevivientes	Survivors' Foundation
GGM	Grupo Guatemalteco de Mujeres	Guatemalan Women Group
INACIF	Instituto Nacional de Ciencias Forenses	National Institute for forensic science
MP	Ministerio Público	Attorney General's Office
MSF-CH	Médicos sin Fronteras	Médecins Sans Frontières
MOH	Ministerio de Salud Pública y Asistencia Social	Ministry of Public Health and Social Assistance
NGOs	Organizaciones no gubernamentales	Non Governmental Organizations
OAV	Oficina de Atención a la Víctima	Victims' Assistance Office
OGs	Organizaciones Gubernamentales	Governmental Organizations
OPS	Organización Panamericana de Salud	Pan American Health Organisation
PNSM	Programa Nacional de Salud Mental	National Program of Mental Health
PNUD	Programa de NU para Desarrollo	UN Development Program
PROPEVI	Programa de Prevención y Erradicación de la Violencia Intrafamiliar	Programme for the prevention and eradication of domestic violence
PTSD	Post Traumatic Stress Disorders	Post Traumatic Stress Disorders
REDICAM	Red Integral de Apoyo a Mujeres. Integral Support Women 's Network	Integrated Network for the Support of Women.

Annex - 5

List of Documents:

- Organization Chart of Mission 2009
- Sample medical/incident chart and medical certificate
- Stories of Sexual Violence
- Flyer of MSF Services
- Guatemala evaluation Questions
- Evaluation Schedule
- Medical services kit – Santa Elena
- Number of Sexual Violence patients attended 2008
- MSF/epicentre – Prevalence of Survivors of forced sexual intercourse among women visiting the peripheral health centre of Zone 18, Guatemala City: a cross-sectional survey. 2nd Draft October 2008
- Final Report Lise Johnson, April, May 2008
- Kelly's final Report: Community Health Nurse account of communication/outreach programs.
 - Includes Appendix: Capitalizacion [sic] Report of Experience de MSF, Sexual Violence project, Guatemala City, 2007
 - Workshop Agendas: Violence, Sexual Violence, Sexual Reproductive Health
 - Hospital Services (Spanish)
 - Synthesis of Community Groups in Zone 18
 - Mobile clinics – schedules, patients
- Agenda and Objectives for Field Visit January 2008
- Field Visit report Guatemala: Treatment of survivor of SV in the zone 18 and 7 of Guatemala city. Maryline Mulemba, January 2008
- Mission Report: Project "Treatment of SV survivors" in Guatemala City, Laure Wolmark, Flying violence officer, 5 jan-10 Feb 2008
- Field vsits – RP cell 4, Phil Humphris, Guatemala 19- 24 Aug 2008
- Annex Legal Questions (French)
- Field Visit Report – Frank Doerner April 2007
- Communication Strategy: Sexual Violence in Urban Areas MSF Ch
- Sitrep- Guatemala MSF CH December 2008, HoM Fabio Forgione
- Sitrep- Guatemala MSF CH November 2008, HoM Fabio Forgione
- Sitrep- Guatemala MSF CH October 2008, HoM Fabio Forgione
- Sitrep- Guatemala MSF CH September 2008, HoM Fabio Forgione
- Sitrep- Guatemala MSF CH August 2008, HoM Fabio Forgione
- Sitrep- Guatemala MSF CH May 2008, HoM Edgardo Zuniga
- Sitrep- Guatemala MSF CH January/February 2008, HoM Alain rias
- Security Guidelines Guatemalan Mission December 2008
- External Threats linked to the context of operations
- Measures and Procedures of Risk Reductions: External and Internal Threats January 2009
- MSF CH: Proposal for an exploratory Mission on Violence In Guatemala, Susanna Christofani
- Project proposal, Comprehensive care to Sexual Violence Survivors, August 2006
- Project proposal, Comprehensive care to Sexual Violence Survivors, February 2007

- Report: Exploratory mission on Violence in Guatemala, Draft 1: Chus Lucas
- Antiretroviral Treatment for people with HIV in Guatemala, Evaluation Ex-post: 2001-2005 Vera Bensmann February 2007
- Epicentre: One year after Hand-over evaluation, Roosevelt programme, Guatemala; Tela programme, Honduras , Dominique van Beckhoven August 2007
- Debriefing Guatemala Perception
- Evaluation of MSFCH's Programme for Street Children. Tegucigalpa, Honduras, Sept 19 – Oct 13, 2007, Carmen Rodriguez, Theo Keuzen
- Country policy paper, HoM Fabio Forgione, September 2008,
 - Annex 2: Project Justification and Strategy Sheet, Sexual Violence, HoM Fabio Forgione October 2008
 - Annex 3: Project Justification and Strategy Sheet, Explo: Migration, HoM Fabio Forgione First Trimester, 2008
 - Annex 4: Project Justification and Strategy Sheet, Explo: Nutrition/Food Insecurity, HoM Fabio Forgione First Trimester, 2008
- Notes and Recommendations on the New (2007) format of MSF Ch logical frameworks
- Project Plan of Action 2009- Medical and Psychological Care for Survivors of Sexual Violence
- Project Plan of Action Overview Sheet 2008
- Activity Timeline, Coordination Team, November 5, 2007
- Project Justification and Strategy sheet, Sexual Violence November 2007, Alian Riass HoM
- Project Justification and Strategy, Project Coordination sheet November 2007, Alian Riass HoM